Lehigh County Adult Blended Case Management (BCM) Criteria Form

Name: ___________________________________ Today's Date: _________________

Serious and persistent mental illness which interferes with the person's capacity to function over a prolonged period of time in important aspects of daily life, i.e. self-direction, employment, education, self-care, recreation and interpersonal relationships.

THE PERSON MUST MEET TWO OF THE THREE FOLLOWING CRITERIA TO BE REFERRED FOR AND ADMITTED FOR BCM SERVICES.

Check which of the following BCM admission Criteria the client meets (can be more than one):

- ☐ Criteria #1 – DIAGNOSIS
  DSM IV Diagnosis of Schizophrenia or Chronic Mood Disorder (295 & 296)

- ☐ Criteria #2 – TREATMENT HISTORY

  ____ Admission to a state mental hospital totaling 60 days within the past two years, or

  ____ Two admissions to community inpatient psychiatric units totaling 20 or more days within the past two years, or

  ____ Five or more face-to-face contacts with emergency services within the past two years, or

  ____ Three or more years of continued attendance in a community MH service, or

  ____ History of sporadic course of treatment evidenced by at least three missed appointments within the past six months, inability to or unwillingness to maintain medication regimen or involuntary commitment to MH outpatient treatment

- ☐ Criteria #3 – Global Assessment of Functions Scale

  ____ 40 and below, or

  ____ 60 or below if person is thirty-five years of age or younger and/or history of aggressive or violent behaviors (explain)

  ____

Using the criteria you checked off above as your guide; provide justification for why you are requesting BCM for this client. (For example – if the client meets criteria #2 because the client had 3 or more acute inpatient psych treatments in the past 12 months, please list the dates of these acute inpatient treatments, etc.).

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Lehigh County Mental Health
Blended Case Management Referral Form

Name: ________________________________ Date of Referral: ________________________

Date of Birth: ______________ Sex: ________ SS #: _________________________________

Address: _____________________________ Phone #: ______________________________

_____________________________ Phone #: ______________________________

Primary Language: ___________________ Relationship Status: ________ (S, M, W, D, Paramour)

Current Living Arrangement: ____

Community Connections: ____

Emergency Contact/Guardian's Name (if applicable): ____

Current MH Treatment Provider and Phone #: ____

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Axis I: ____

Axis II: ____

Axis III: ____

Axis IV: ____

Axis V: ____

Referral must include:
- **psychiatric or diagnostic evaluation**
- **treatment notes**
- **current medication list**

Send medical information as needed.

History of: (please circle all that apply)

Sexual Abuse Suicide Assault/Aggressive Behavior Fire Setting

Treatment History (including D&A):____

____

Decompensation Pattern: ____

____

Insurance: ________________________ Income & Source: _________________________________

Other Agency Involvement (Please list all that apply. Attach extra sheets as necessary.):

Name / Contact Information: ____

Name / Contact Information: ____

Reason for Referral for BCM: ____

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Referring Staff: ____________________________________ Phone: _________________________

Referring Agency: ____